

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00492

510

CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 10 North Anne	
3. NAME OF DECEASED (Type or print) First JOHN Middle V. Last ABENDSCHEIN		4. DATE OF DEATH Month January Day 9 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-93
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 6 Days 3 Hours 4 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		11b. KIND OF BUSINESS OR INDUSTRY unknown	
11c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Abendschein		14. MOTHER'S MAIDEN NAME Mary Raider	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial fibrosis left ventricle, interventricular septum (c) Coronary arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6-8 days unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general, severe - unknown. Tuberculosis, minimal, inactive, right upper lobe - un-		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) known	
20c. TIME OF INJURY Month, Day, Year Hour a. m. VA p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 30, 19 45 to January 9, 19 57 , and that death occurred at 8:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W. Oppler M.D. V.A. Hospital, Perry Point, Md. 1-10-57 PHYSICIAN'S NAME (Type) W. OPPLER Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-10-57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 1-11-57	
24b. REGISTRAR'S SIGNATURE Irene E. Dougherty			

RECEIVED

511 CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit				c. LENGTH OF STAY IN 1b 72 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 37 S. Main St.				d. STREET ADDRESS 37 S. Main St.			
3. NAME OF DECEASED (Type or print) First Margaret Middle C. Last Abrahams				4. DATE OF DEATH Month 1 Day 17 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-23-1879	
9. AGE (In years last birthday) 77		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Scotland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Cropper				14. MOTHER'S MAIDEN NAME Jane Emery			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT Address Lewis W. Abrahams, Port Deposit, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 1-13, 1952, to 1-17, 1957, that I last saw the deceased alive on 1-12, 1952, and that death occurred at 8:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) Port Deposit, Md.			
DATE SIGNED 1-15-57							
PHYSICIAN'S NAME (Type) G.H. Richards Jr. M.D.							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-21-1957		22c. NAME OF CEMETERY OR CREMATORY Hopewell		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE 1-21-57	
24b. REGISTRAR'S SIGNATURE [Signature]							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. AISME(5)
SM 9/55

1. PLACE OF DEATH o. COUNTY		Cecil MARYLAND	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		o. STATE Conn b. COUNTY Fairfield	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
North East	On Road	Fairfield 458-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	e. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Route 40 and Route 272	1983 King Highway		
3. NAME OF DECEASED (Type or print)		First Middle Last	
Ella Magoaleha Baker		4. DATE OF DEATH Month Day Year Jan. 29 19 57	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
F	W		2-17-1902
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Cook	Private Res.	11. BIRTHPLACE (State or foreign country) Fairfield , Conn	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Ellis	
14. MOTHER'S MAIDEN NAME No information		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. o45-22-8598		17. INFORMANT Address Wallace Baker, 1983 Kings Hing	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Compound Fracture of right frontal bone with loss of right eye			
(b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit the left side of tractor trailer	
20c. TIME OF INJURY Hour p. m. 8:35 1-29-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40		20f. (City or town) North East Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		DATE SIGNED 1-29-57	
EXAMINER'S NAME (Type) R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-29-57	
22c. NAME OF CEMETERY OR CREMATORY Mountain Grove		22d. LOCATION (City, town, or county) Bridgeport Conn	
23. EMPLOYER'S SIGNATURE		24a. REC'D BY REGISTRAR DATE 2/1/57	
24b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. The text is mostly illegible due to the quality of the scan.

BUREAU V. 2

FEB 4 1957

RECEIVED

William J. ...
...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

513

CERTIFICATE OF DEATH

00495

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colora		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colora	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Annie Balderston		4. DATE OF DEATH Month Day Year Jan. 8 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1889
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Nurse		10b. KIND OF BUSINESS OR INDUSTRY Registered Nurse	
11. BIRTHPLACE (State or foreign country) Colora, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Balderston		14. MOTHER'S MAIDEN NAME Myra Atwater	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes World War		16. SOCIAL SECURITY NO.	
17. INFORMANT Bertha Balderston		Address Colora, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Bladder (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1956, to Jan 6, 1957, that I last saw the deceased alive on Jan 6, 1957, and that death occurred at 10 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE CLARENCE E. BENSON		M.D. Port Deposit, Md. - 1/9/57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Jan. 11, 1957	
22c. NAME OF CEMETERY OR CREMATORY Silverbrook Crem.		22d. LOCATION (City, town, or county) (State) Wilmington Del.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson		ADDRESS Residing Sun rd, Del	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Loom Wilmington	

BUREAU V. S.

JAN 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

514

CERTIFICATE OF DEATH

00496

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsburgh 75x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 632 Lowell Street			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last CHILDRESS				4. DATE OF DEATH Month January Day 27 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-20-1889	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Jackson Childress				14. MOTHER'S MAIDEN NAME Willie Scott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I Unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general, severe							INTERVAL BETWEEN ONSET AND DEATH 3-4 days unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 1. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 9, 1944, to January 27, 1956, and that death occurred at 8:00 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. A. Hospital, Perry Point, Md. 1-28-57				DATE SIGNED			
PHYSICIAN'S NAME (Type) W. OPPLER				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-28-57		22c. NAME OF CEMETERY OR CREMATORY Beverly National		22d. LOCATION (City, town, or county) (State) Beverly, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Remington & Son, Hayre de Grace, Md.				24a. REC'D BY REGISTRAR DATE 1-30-57		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JACKSON, CHARLES		MALE		45		JAN 15 1912	
PLACE OF BIRTH		RACE		OCCUPATION		EDUCATION	
BALTIMORE, MARYLAND		WHITE		LABORER		HIGH SCHOOL	
MARRIAGE		MOTHER		FATHER		DATE OF DEATH	
MARRIED		JACKSON, MARY		JACKSON, JOHN		FEB 1 1957	
DATE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JAN 15 1957		FEB 1 1957		BALTIMORE, MARYLAND		HEART DISEASE	
MANNER OF DEATH		CERTIFICATE NO.		REGISTERED		FILED	
NATURAL		1-1-57		YES		YES	
DATE OF REGISTRATION		DATE OF FILING		DATE OF INDEXING		DATE OF POSTING	
FEB 1 1957		FEB 1 1957		FEB 1 1957		FEB 1 1957	

BUREAU V. 3

FEB 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

515

CERTIFICATE OF DEATH

00497

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace 12-24-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 112 S. Union Avenue	
3. NAME OF DECEASED (Type or print) First John Middle Lawrence Last CONCES		4. DATE OF DEATH Month 1 Day 11 Year 1957	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-57
9. AGE (In years last birthday) yrs.		10. BIRTHPLACE (State or foreign country) Bainbridge, Md.	
11. CITIZEN OF WHAT COUNTRY? U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Lawrence CONCES		14. MOTHER'S MAIDEN NAME Patricia Joanne ZYGMUNT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suspected Intracranial Hemorrhage 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-10-57, 1957, to 1-11-57, 1957, that I last saw the deceased alive on 1-11-57, 1957, and that death occurred at 4:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) PETER R. DALLMAN, LT MC USN, BAINBRIDGE, MARYLAND 1-11-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-12-57	
22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cemetery		22d. LOCATION (City, town, or county) (State) Colora, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ed Patterson Son, Perryville, Md		24a. REC'D BY REGISTRAR DATE 1-11-57	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

516

CERTIFICATE OF DEATH

00498

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 18 x 22 Hollywood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EUGENE Middle I. Last CONNOR		4. DATE OF DEATH Month January Day 4 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-9-1892
9. AGE (In years lost birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bojan Connor		14. MOTHER'S MAIDEN NAME Nellie (?)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1420.1 Bronchopneumonia, unresolved, right lower lobe DUE TO (b) Coronary arteriosclerosis severe DUE TO (c) Arteriosclerosis, general, severe CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 7-10 days unknown unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 27, 1950, to January 4, 1957, and that death occurred at 8:10 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		M.D. V.A. Hospital, Perry Point, Md. 1-4-57	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-4-57	
22c. NAME OF CEMETERY OR CREMATORY St. Aloysius		22d. LOCATION (City, town, or county) (State) Leonardtown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 1-5-57	
24b. REGISTRAR'S SIGNATURE Irene E. Dougherty			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>	
<p>9. MEDICAL HISTORY [REDACTED]</p>		<p>10. SIGNATURE OF PHYSICIAN [REDACTED]</p>	
<p>11. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>12. DATE OF DEATH [REDACTED]</p>	
<p>13. PLACE OF DEATH [REDACTED]</p>		<p>14. TIME OF DEATH [REDACTED]</p>	
<p>15. SIGNATURE OF WITNESS [REDACTED]</p>		<p>16. SIGNATURE OF DECEASED [REDACTED]</p>	

BUREAU V. S.

JAN 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00500

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 12 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS 108 Hollingworth Manor			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Louise Jean Creswell				4. DATE OF DEATH Month Day Year Jan. 25 19 57			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-9-54		9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George E. Creswell				14. MOTHER'S MAIDEN NAME Louise Bolton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT George E. Creswell		Address Elkton. Md. 108 Hollingworth	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) First and Second degree burns of back 917.0 DUE TO back and right arm. Conditions, if any, which gave rise to immediate cause (b) Hypostatic Pneumonia. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pulled a hot Pot of coffee on herself					
20c. TIME OF INJURY Month, Day, Year Hour Min. p. m. 1-21-57		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Elkton Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-25-56			
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/27/57		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Methodist		22d. LOCATION (City, town, or county) (State) Cecil Md	
23. FUNERAL DIRECTOR'S SIGNATURE H. Walter de Boer Jr				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE 1/27/57	
						24b. REGISTRAR'S SIGNATURE J.P. Frazer	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO MEDICAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 30 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

518

CERTIFICATE OF DEATH

00501

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle (NMI) Last CROSBY		4. DATE OF DEATH Month January Day 24 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-20-91
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ira Crosby		14. MOTHER'S MAIDEN NAME Eliza (?)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 578 22 7257	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, right lung, unresolved 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pyelonephritis, bilateral--staphylococcus albus DUE TO (c) unknown INTERVAL BETWEEN ONSET AND DEATH 4-5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general, severe - unknown		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 2, 19 56, to January 24, 19 57, and that death occurred at 4:15 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		DATE SIGNED V.A. Hospital, Perry Point, Md. 1-25-57	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-25-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PENNINGTON & SON, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 1-25-57	
24b. REGISTRAR'S SIGNATURE [Signature]			

WYOMING STATE DEPARTMENT OF SOCIAL SERVICES

100-443887-100

4-10-1962

1991

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U.S. DEPARTMENT OF AGRICULTURE

BUREAU V. 1
JAN 28 1957

RECEIVED
JAN 28 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

519

CERTIFICATE OF DEATH

00502

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conowingo, Rural				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rowlandville				d. STREET ADDRESS Rowlandville			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Gaylord Curry				4. DATE OF DEATH Month Day Year 1 2 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-4-1906	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter				10b. KIND OF BUSINESS OR INDUSTRY Gen. Construction.			
11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William C. Curry				14. MOTHER'S MAIDEN NAME Ella Billingsley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 213-12-5173			
17. INFORMANT Marie Z. Curry, Conowingo, Md. R F D.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12/3/1956, to 1/2/1957, that I last saw the deceased alive on 12/3/1956, and that death occurred at 125 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Dudley Phillips M.D. Darlington Md 1/3/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Dudley Phillips, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-5-1957		22c. NAME OF CEMETERY OR CREMATORY Hopewell		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE C. A. Patterson & Son				ADDRESS Perryville, Md.			
24a. REC'D BY REGISTRAR DATE 1-3-57				24b. REGISTRAR'S SIGNATURE D. E. Dougherty			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 2 1957		BALTIMORE, MARYLAND	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		12345		YES	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		HISTORY OF DRUGS	
JAN 1 1912		BALTIMORE, MARYLAND		HIGH SCHOOL		MARRIED		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
JAN 2 1957		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL		12345		YES	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		HISTORY OF DRUGS	
JAN 1 1912		BALTIMORE, MARYLAND		HIGH SCHOOL		MARRIED		NONE		NONE	

BUREAU V. 2

JAN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, the body should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00503

520

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 1 mo. 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ENRICO Middle DI Last VINCENTIS		4. DATE OF DEATH Month January Day 21 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-12-1890
9. AGE (In years lost birthday) yrs. 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic (Retired)	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Angelo DiVincentis - Deceased		14. MOTHER'S MAIDEN NAME Marie Tonnella - Deceased	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laennec's cirrhosis 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Aortic stenosis due to arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. VA 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 14, 19 56 , to January 21, 19 57 , and that death occurred at 10:40a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		M.D. V.A. Hospital, Perry Point, Md. 1-21-57	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-21-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Erin		22d. LOCATION (City, town, or county) (State) Havre de Grace, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 1-24-57	
24b. REGISTRAR'S SIGNATURE Irvin E. Daugherty			

BUREAU V. S.

1957 28 NOV

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

496 CERTIFICATE OF DEATH

00504

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2-Calvert		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS R. F. D.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Duane ECCLES				4. DATE OF DEATH Month Day Year January 26 1957			
5. SEX M	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 25, 1867		9. AGE (In years lost birthday) yrs. 89	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Lumberman		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Eccles				14. MOTHER'S MAIDEN NAME No Information			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Address Albert Eccles, Nottingham, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Chronic Myocarditid DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis and urinal retention DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-4-57, 19 to 1-27, 1957, that I last saw the deceased alive on 1-27, 1957, and that death occurred at 2:30 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE R. C. Dodson				ADDRESS (Street, city or town, state) Rising Sun, Md.		DATE SIGNED 1-27-56	
PHYSICIAN'S NAME (Type) R. C. Dodson							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-29-1957		22c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		22d. LOCATION (City, town, or county) (State) R. D. Port Deposit Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Riffin				24a. REC'D BY REGISTRAR DATE 1/30/57		24b. REGISTRAR'S SIGNATURE J. R. Frazer	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1882		BALTIMORE		BALTIMORE		MARYLAND	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE	
MARRIED		1905		BALTIMORE		BALTIMORE		BALTIMORE		1905		BALTIMORE		BALTIMORE	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		DATE OF GRADUATION		PLACE OF GRADUATION		CITY OF GRADUATION		COUNTRY OF GRADUATION	
HIGH SCHOOL		BALTIMORE		BALTIMORE		BALTIMORE		1900		BALTIMORE		BALTIMORE		BALTIMORE	
PROFESSION		OCCUPATION		INDUSTRY		DATE OF ENTRY		PLACE OF ENTRY		CITY OF ENTRY		COUNTRY OF ENTRY		DATE OF DEPARTURE	
LABORER		LABORER		LABORER		1900		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT		COUNTRY OF INTERMENT	
FEB 1 1937		BALTIMORE		BALTIMORE		BALTIMORE		FEB 1 1937		BALTIMORE		BALTIMORE		BALTIMORE	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		COUNTRY		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	
JAMES H. HARRIS		1937		BALTIMORE		BALTIMORE		BALTIMORE		1937		BALTIMORE		BALTIMORE	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		COUNTRY		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	
JAMES H. HARRIS		1937		BALTIMORE		BALTIMORE		BALTIMORE		1937		BALTIMORE		BALTIMORE	

BUREAU V. S.

FEB 1 1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG210 1-29-57 et

521

CERTIFICATE OF DEATH

Reg. Dist. No. 00505

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rising Sun</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rising Sun</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Edwards</u> Last <u>Edwards</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 8, 1906</u>	
9. AGE (In years last birthday) <u>50</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Former</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Richard Edwards</u>			
14. MOTHER'S MAIDEN NAME <u>Emma Moxley</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>242-14-0473</u>				17. INFORMANT <u>Pauline Edwards</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of pancreas</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 year</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>53</u> to <u>1/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/19</u> , 19 <u>57</u> , and that death occurred at <u>9 A</u> . M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Neal Taylor</u> M.D.				ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u>			
DATE SIGNED <u>1/19/57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/22/57</u>		<u>Methodist Church</u>		<u>Shilo N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed, Rising Sun, Md.</u>				ADDRESS <u>Rising Sun, Md.</u>		24. REC'D BY REGISTRAR <u>Jan 19-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>L M McKnight</u>			

OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4
DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 14

BUREAU V. S.

JAN 22 1957

RECEIVED

522

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville, Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Perryville, Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Aikin		d. STREET ADDRESS Aikin	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sallie Middle J. Last Fisher		4. DATE OF DEATH Month 1 Day 10 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1863
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Curtis E. Fisher, Rising Sun, Md. Rural		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Chronic Thyrocarditis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 8, 1957, to Jan 11, 1957, and that death occurred at 11:00 A.M. from the causes and on the date stated above.		21. I certify that I last saw the deceased alive on Jan 8, 1957, and that death occurred at 11:00 A.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Clarence I. Benson, M.D.		DATE SIGNED Jan 11, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-12-1957	
22c. NAME OF CEMETERY OR CREMATORY St. Marks		22d. LOCATION (City, town, or county) (State) Perryville, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE L. A. Patterson, Son, Perryville, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE 1-12-57		24b. REGISTRAR'S SIGNATURE Inez E. Dougherty	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
JAN 15 1957		BALTIMORE, MARYLAND	
DECEASED'S NAME		SEX	
JOHN J. BROWN		MALE	
AGE		RACE	
65		WHITE	
DATE OF BIRTH		PLACE OF BIRTH	
JAN 15 1892		BALTIMORE, MARYLAND	
OCCUPATION		CAUSE OF DEATH	
FIRE INSURANCE AGENT		HEART DISEASE	
MANNER OF DEATH		MEDICAL ATTENDANCE	
NATURAL		YES	
PLACE OF INTERMENT		CITY OF DEATH	
CATHOLIC CEMETERY		BALTIMORE, MARYLAND	
SIGNATURE OF DECEASED'S NEAREST RELATIVE		SIGNATURE OF PHYSICIAN	
JOHN J. BROWN		JOHN J. BROWN	
DATE		DATE	
JAN 15 1957		JAN 15 1957	

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JAN 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

523

CERTIFICATE OF DEATH

00507
94

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON b. COUNTY D C	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 1 mo. 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1451 N Street, NW	
3. NAME OF DECEASED (Type or print) First GEORGE Middle FINLEY Last FRANKLIN		4. DATE OF DEATH Month January 22 Day 19 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1890
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman (retired)	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT FRANKLIN		14. MOTHER'S MAIDEN NAME MARTHY COFFEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I 578-28-9738	
17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Bronchopneumonia, bilateral, unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2. Pyelonephritis, left DUE TO (c) 3. Prostatic hypertrophy, benign		INTERVAL BETWEEN ONSET AND DEATH 5 to 6 days Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, moderate		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. Month 19 Day 19 Year 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 12 , 19 56 , to Jan. 22 , 19 57 , and that death occurred at 8:00 P. M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE W. Oppler M.D. Perry Point, Maryland		1-23-57	
PHYSICIAN'S NAME (Type) W. OPPLER, M.D., Director, Professional Services, VAH., Perry Point, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-28-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers		24a. REC'D BY REGISTRAR AN 28 1957	
ADDRESS 1400 Chapin Ave. Wash. D.C.		24b. REGISTRAR'S SIGNATURE Lrene Dougherty	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		SEX	
MARRIAGE		RACE	
EDUCATION		RELIGION	
BIRTH		DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
DISEASE		INJURY	
SYMPTOMS		TREATMENT	
HISTORY		FAMILY HISTORY	
SOCIAL HISTORY		HABITS	
OCCUPATIONAL HISTORY		TRAVEL HISTORY	
MEDICAL HISTORY		SURGICAL HISTORY	
PATHOLOGICAL FINDINGS		LABORATORY FINDINGS	
POSTMORTEM FINDINGS		TOXICOLOGICAL FINDINGS	
FORENSIC FINDINGS		LEGAL FINDINGS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

JAN 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00508

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural				c. LENGTH OF STAY IN lb 4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mattie Esther Gerhard				4. DATE OF DEATH Month 1 Day 24 Year 19 59			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-14-1913	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY House work		11. BIRTHPLACE (State or foreign country) Smith Co. Va.	
13. FATHER'S NAME David Powers				14. MOTHER'S MAIDEN NAME Callie Stocks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 238-34-6685		17. INFORMANT Charley Gerhard, Rising Sun, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 593X Acute Coronary Occlusion DUE TO (b) Nephritis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1 INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				DATE SIGNED 1-24-59			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Jan 27, 1958		22c. NAME OF CEMETERY OR CREMATORY Over Nottingham		22d. LOCATION (City, town, or county) (State) Cecil Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson				ADDRESS Rising Sun, Md.		24. REGISTRAR'S SIGNATURE L.M.V. Whitington	

BUREAU V. S.

JAN 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00509

Reg. Dist. No. 96

525

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Perryville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Elm St.</u>		d. STREET ADDRESS <u>1 Elm St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>May</u> Last <u>Gillespie</u>		4. DATE OF DEATH Month <u>1</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter Gillespie</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Harris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Irene Sentman, Perryville, Md</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Sclerosis</u> <u>334x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bilelitis Left Leg</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 10, 1957</u> to <u>Jan 17, 1957</u> , that I last saw the deceased alive on <u>Jan 17, 1957</u> , and that death occurred at <u>3:30</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. I. Benson</u>		ADDRESS (Street, city or town, state) <u>Port Deposit, Md</u>	
PHYSICIAN'S NAME (Type) <u>C. I. Benson, M.D.</u>		DATE SIGNED <u>1/18/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-20-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Irene E. Dougherty</u>	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

497

CERTIFICATE OF DEATH

Reg. Dist. No.

00519

1. PLACE OF DEATH o. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>WHITE CRYSTAL BEACH, EARLEVILLE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>M.</u> Last <u>GREEN</u>				4. DATE OF DEATH <u>JAN.</u> Month <u>16</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 26, 1906</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESORT MANAGER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SUMMER RESORT</u>		11. BIRTHPLACE (State or foreign country) <u>WILM. DEL.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>ALFRED GREEN</u>				14. MOTHER'S MAIDEN NAME <u>ETHEL PEARCY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>222-03-8085</u>		17. INFORMANT <u>MRS. ETHEL GREEN</u> Address <u>EARLEVILLE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Cerebral Metastases</u> DUE TO (c) <u>Carcinoma of Breast</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>multiple bone and visceral metastases</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>Jan</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 16</u> , 19 <u>57</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace Oberstain</u> M.D.				ADDRESS (Street, city or town, state) <u>Cecilton, Md.</u> DATE SIGNED <u>18 Jan 57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CECILTON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CECILTON MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Hellous</u> ADDRESS <u>Millington, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. R. Frager</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
526
CERTIFICATE OF DEATH

00511

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chatham			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle J. Last GREENE				4. DATE OF DEATH Month January Day 3 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-3-93	9. AGE (In years lost, birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Arteriosclerotic coronary heart disease, severe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial fibrosis interventricular septum DUE TO (c) Arteriosclerosis, general, severe							INTERVAL BETWEEN ONSET AND DEATH unknown unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. VA 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 6, 19 23, to January 3, 19 57, that I saw the deceased alive on January 3, 19 57, and that death occurred at 9:30 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Oppler				ADDRESS (Street, city or town, and state) V.A. Hospital, Perry Point, Md. DATE SIGNED 1-4-57			
PHYSICIAN'S NAME (Type) W. OPPLER				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 1-4-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Hare de la Harpe Md.				24a. REC'D BY REGISTRAR DATE Jan 8-57		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

BUREAU V. S.

1957 10 JAN

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>ELKTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD #3 Box 4 ELKTON</u>		d. STREET ADDRESS <u>RFD #3 Box 4</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDNA B. HAMM</u>		4. DATE OF DEATH Month Day Year <u>JAN 6 19 57</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 20, 1895</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		9b. AGE (In years last birthday) <u>61</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT BREEDING</u>		14. MOTHER'S MAIDEN NAME <u>NO RECORD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>221-05-688</u>	
17. INFORMANT <u>WALTER J. HAMM</u>		Address <u>BOX 4 RFD #3 ELKTON, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>Cardiovascular renal</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. m. Month Day Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>57</u> to <u>Jan 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>57</u> , and that death occurred at <u>8 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert Bates</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>2302 Main St Elkton Md 1/7/57</u>	
PHYSICIAN'S NAME (Type) <u>J. HERBERT BATES</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/10/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEWARK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>NEWARK DEL.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.T. Jones</u>		ADDRESS <u>Newark, Del.</u>	
24a. REC'D BY REGISTRAR DATE <u>Jan 11</u>		24b. REGISTRAR'S SIGNATURE <u>JR Jager</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA		MOBILE		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
JAN 4 1968		MEMPHIS, TENNESSEE		MEMPHIS		UNITED STATES		JAN 4 1968		MEMPHIS, TENNESSEE		MEMPHIS		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
HEART DISEASE		NATURAL		FARMER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
JAN 4 1968		MEMPHIS, TENNESSEE		MEMPHIS		UNITED STATES		JAN 4 1968		MEMPHIS, TENNESSEE		MEMPHIS		UNITED STATES	

RECEIVED
JAN 14 1968
BUREAU V. 2

528

CERTIFICATE OF DEATH

Reg. Dist. No.

00513

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 3 mo. 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22-12-2 Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 713 Camden Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM		Middle C.		Last HARRINGTON		4. DATE OF DEATH Month January	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-3-95	
9. AGE (In years last birthday) 61		10. IF UNDER 1 YEAR Months 25		11. IF UNDER 24 HRS. Days 19		12. Year 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Harrington				14. MOTHER'S MAIDEN NAME Isadora Pritchette			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I & WW II 218 12 1630		17. INFORMANT Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia, Bilateral, Unresolved 355X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Progressive subcortical encephalopathy (Paralysis agitans) DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 4 - 5 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 12, 1956 to January 25, 1957 , and that death occurred at 1:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 1-26-57 ACTUAL SIGNATURE Joseph C. Grasperger M.D. PHYSICIAN'S NAME (Type) JOSEPH C. GRASBERGER, M.D., Acting Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 1-26-57		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson		ADDRESS 705 East Main St., Salisbury, Md.		24a. REC'D BY REGISTRAR 1-26-57		24b. REGISTRAR'S SIGNATURE Lucius E. Blough	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
John Doe		Male		45		Jan 15, 1912		Baltimore		Baltimore		Baltimore		Maryland	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		DATE OF MARRIAGE		PLACE OF MARRIAGE		STATE OF MARRIAGE	
None		None		None		None		None		None		None		None	
OCCUPATION		PROFESSION		EDUCATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE		NAVY SERVICE		AIR FORCE SERVICE	
None		None		None		None		None		None		None		None	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF ONSET		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		STATE OF DEATH	
Heart Disease		Natural		10 days		Jan 10, 1957		Jan 15, 1957		10:00 AM		Baltimore		Maryland	
SIGNS AND SYMPTOMS		HISTORY OF PRESENT ILLNESS		HISTORY OF PREVIOUS ILLNESSES		HISTORY OF SURGERY		HISTORY OF DRUGS		HISTORY OF ALCOHOL		HISTORY OF TOBACCO		HISTORY OF OTHER HABITS	
Chest pain, shortness of breath		Onset of chest pain, shortness of breath, 10 days prior to death		None		None		None		None		None		None	
FAMILY HISTORY		SOCIAL HISTORY		PERSONAL HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		RADIOLOGIC EXAMINATIONS		PATHOLOGIC EXAMINATIONS		OTHER EXAMINATIONS	
None		None		None		None		None		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF NURSE		SIGNATURE OF CHAPLAIN	
None		None		None		None		None		None		None		None	

BUREAU V. S.

JAN 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00514

529

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 113 33rd Street, N.E.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle A. Last Harris				4. DATE OF DEATH Month 1 Day 26 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-85		9. AGE (In years last birthday) yrs. 71	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian (Retired)				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George W. Harris (Deceased)				14. MOTHER'S MAIDEN NAME Ann Kernard (Deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WW1 & WW2		17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease, severe. DUE TO (c) Arteriosclerosis, generalized, severe.						INTERVAL BETWEEN ONSET AND DEATH 3-4 days Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-31 , 19 56 , to 1-26 , 19 57 , that I was the cause of death, and that death occurred at 3:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, Perry Point, Md. 1-26-57							
ACTUAL SIGNATURE Joseph C. Grasperger M.D. VAH, Perry Point, Md.							
PHYSICIAN'S NAME (Type) JOSEPH C. GRASBERGER, M.D., Acting Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal		1-27-57 1/29/57		Baltimore National		Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Kate R. Wilborn				ADDRESS		24a. REC'D BY REGISTRAR DATE 1-27-57	
						24b. REGISTRAR'S SIGNATURE Irene E. Daugherty	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD. CERTIFICATE OF DEATH

Reg. No. 100-100-100

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

US. CITIZENSHIP

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF CREMATOR

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

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NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

BUREAU V. S.

JAN 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon poppers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00515

Reg. Dist. No.

91

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MORGAN NURSING HOME</u>		d. STREET ADDRESS <u>12 CHESAPEAKE CITY</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHERINE V. HOWARD</u>		4. DATE OF DEATH Month Day Year <u>JAN. 8 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 23, 1866</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN E. FERGUSON</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET E. JONES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HARRY BUDD</u>		Address <u>CECILTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Senility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>years.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>56</u> , to <u>Jan 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 8</u> , 19 <u>57</u> , and that death occurred at <u>4:45 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cecilton, Md</u> DATE SIGNED <u>10 Jan 57</u> ACTUAL SIGNATURE <u>Wallace Oberheim</u> M.D. <u>Cecilton, Md</u> PHYSICIAN'S NAME (Type) <u>Wallace Oberheim</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/11/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CECILTON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>Cecilton MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward H. Mullington</u>		24a. REC'D BY REGISTRAR <u>AN 11 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. Ralph P. Rugg</u>			

CERTIFICATE OF DEATH

MARYLAND



BUREAU V. S.

JAN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00516

498

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH o. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DEVINE HAVEN HOME		e. STREET ADDRESS 1 222 E. MAIN ST.	
3. NAME OF DECEASED (Type or print) First ISABELLE Middle JAMAR Last JAMAR		4. DATE OF DEATH Month JANUARY Day 15 Year 19 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 17, 1876
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN H. JAMAR MD		14. MOTHER'S MAIDEN NAME MARGARET HOLLINGSWORTH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT MARY H. JAMAR		Address ELKTON, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio vascular renal DUE TO (c) Arterio sclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 hours 10 years 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 30 , to Jan 15 , 19 57 , that I last saw the deceased alive on Jan 15 , 19 57 , and that death occurred at 6:45 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Elkton Md DATE SIGNED J. Herbert Bates			
ACTUAL SIGNATURE J. Herbert Bates		M.D. Elkton Md	
PHYSICIAN'S NAME (Type) J. HERBERT BATES			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JAN. 18, 1957	22c. NAME OF CEMETERY OR CREMATORY PRESBYTERIAN	22d. LOCATION (City, town, or county) (State) ELKTON, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pizzari		ADDRESS ELKTON, Md.	
24a. REC'D BY REGISTRAR IR Frazier		24b. REGISTRAR'S SIGNATURE IR Frazier	

499

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				d. STREET ADDRESS <u>R. F. D. # 1</u>			
3. NAME OF DECEASED (Type or print) First <u>Sofia</u> Middle <u>M.</u> Last <u>Jensen</u>				4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6, 1873</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>83</u>	IF UNDER 24 HRS. Days <u>83</u> Hours <u>83</u> Min. <u>83</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>		11. BIRTHPLACE (State or foreign country) <u>Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Michael Pedersen</u>				14. MOTHER'S MAIDEN NAME <u>No Information</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes, give year or dates of service</u>		16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT <u>Paul Jensen, R. F. D. # 1, Elkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>442X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio vascular renal</u> DUE TO <u>10 years</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19 <u>55</u> , to <u>Jan 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 23</u> , 19 <u>57</u> , and that death occurred at <u>4:20 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Herbert Bates</u>				ADDRESS (Street, city or town, state) <u>Elkton Md.</u> DATE SIGNED <u>Jan 24. 57</u>			
PHYSICIAN'S NAME (Type) <u>J. HERBERT BATES</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 27, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Pippin</u> ADDRESS <u>207 E. Main St. Elkton Md. W.D.L.</u>				24a. REC'D BY REGISTRAR <u>1/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>JR. Frazer</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 1 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

00518

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Harris</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>January</u> Day <u>24</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 28 1896</u>		9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.G. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John M. Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Selma Tyson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 1 218-05-0826</u>		17. INFORMANT <u>Mrs John H. Johnson</u> Address <u>North East, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pericarditis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary Atherosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 hr.</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Duodenal Ulcer; Epilepsy.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 Jan 1957</u> , to <u>24 Jan 1957</u> , that I last saw the deceased alive on <u>24 Jan 1957</u> , and that death occurred at <u>8:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Klaus H. Huebner</u>		M.D. <u>North East, Md</u>		DATE SIGNED <u>25 Jan '57</u>			
PHYSICIAN'S NAME (Type) <u>Klaus H. Huebner M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 27, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>North East Cecil, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>				ADDRESS <u>North East, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>25-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dorothy E. Rethermel</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00519

532

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY Cecil <i>Eikton</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City, Md				c. LENGTH OF STAY IN 1b 1 Yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS Ches. City RD1.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED First Middle Last Maude Hollier Johnson				4. DATE OF DEATH Jan. 5 1957			
5. SEX F.	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1883	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Mass.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Charles H. Hollier				14. MOTHER'S MAIDEN NAME Jennie Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No			
17. INFORMANT A. Hallier Johnson				Address R D. 1 Md. Chesapeake City			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Lemonage 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension C.V. Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 days 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 5, 1956, to Jan. 5, 1957, that I last saw the deceased alive on Jan. 4, 1957, and that death occurred at 12:45 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Henry V. Davis</i>				M.D. Chesapeake City, Md			
PHYSICIAN'S NAME (Type) HENRY V. DAVIS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Jan 5/57		22c. NAME OF CEMETERY OR CREMATORY Hopedale Cent		22d. LOCATION (City, town, or county) (State) Hopedale, Mass	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry V. Davis</i>				24a. REC'D BY REGISTRAR DATE Jan 7		24b. REGISTRAR'S SIGNATURE <i>FR Tager</i>	

BUREAU V.

JAN 9 1957

RECEIVED

533

CERTIFICATE OF DEATH

00520

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Cape May ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland		c. LENGTH OF STAY IN 1b 30 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Villas 67X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS 6 E. Florida Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edward Middle M. Last Kropp			4. DATE OF DEATH Month 1 Day 26 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-20-96		9. AGE (In years last birthday) yrs. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Philadelphia, Penna.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Kropp			14. MOTHER'S MAIDEN NAME Esther Moore		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) Yes		16. SOCIAL SECURITY NO. 209 14 3685		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, unresolved, left lung. 223X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cyst of brain, right, cause unknown-involving posterior frontal & anterior parietal lobes. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, severe.					INTERVAL BETWEEN ONSET AND DEATH 6 - 7 days Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-27- , 19 56 , to 1-26- , 19 57 , and that death occurred at 12:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH., Perry Point, Md. 1-26-57					
ACTUAL SIGNATURE Joseph C. Gruberger M.D. VAH., Perry Point, Md. 1-26-57					
PHYSICIAN'S NAME (Type) JOSEPH C. GRASBERGER, M.D., Acting Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 1-28-57	22c. NAME OF CEMETERY OR CREMATORY Beverly National		22d. LOCATION (City, town, or county) (State) Beverly, New Jersey
23. FUNERAL DIRECTOR'S SIGNATURE C.H. IREDELL			24a. REC'D BY REGISTRAR DATE 1-27-57		24b. REGISTRAR'S SIGNATURE James E. Dougherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers.

TO GENERAL DIRECTOR: This certificate has been signed by the attending physician and completed. The funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers.

CERTIFICATE OF DEATH

Name of Deceased [Illegible]		Sex [Illegible]		Date of Birth [Illegible]	
Usual Residence [Illegible]		Place of Birth [Illegible]		Date of Death [Illegible]	
Cause of Death [Illegible]		Immediate Cause [Illegible]		Contributing Cause [Illegible]	
Place of Death [Illegible]		Name of Physician [Illegible]		Name of Hospital [Illegible]	
Name of Informant [Illegible]		Relationship to Deceased [Illegible]		Signature of Informant [Illegible]	
Date of Report [Illegible]		Name of Registrar [Illegible]		Signature of Registrar [Illegible]	

BUREAU V. S.

JAN 29 1957

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1
Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

300

CERTIFICATE OF DEATH

00521

Reg. Dist. No.

92

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 134 W. High St.	
3. NAME OF DECEASED (Type or print) First Middle Last Howard Lewis		4. DATE OF DEATH Month Day Year January 8 19 57	
5. SEX M	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1877
9. AGE (In years lost birthday) yrs. 79		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post Engineer		10b. KIND OF BUSINESS OR INDUSTRY Aberdeen Proving Grounds	
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles E. Lewis		14. MOTHER'S MAIDEN NAME Martha Maxwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 197-10-0527	
17. INFORMANT Miss Carrie Lewis		134 W. High St. Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1, 1956 to Jan. 8, 1957, that I last saw the deceased alive on Jan. 8, 1957, and that death occurred at 8:30 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D.		ADDRESS (Street, city or town, state) 233 E. Main St. Elkton, Md.	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR. M.D.		DATE SIGNED 1/8/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-11-1957	
22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE S. Herring Tappin		24a. REC'D BY REGISTRAR DATE JAN 14 1957	
24b. REGISTRAR'S SIGNATURE L. R. Langer			

BUREAU V. S.

JAN 14 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00522

501

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XOE Elkton RD 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION reunion Hospital				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Little				4. DATE OF DEATH Month Day Year January 28 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 28 - 1957	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Herbert F. Little				14. MOTHER'S MAIDEN NAME m Patricia Bower Va.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Herbert F. Little		Address Elkton RD 1 Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.0 DUE TO Anoxia due to strangulation of umbilical cord Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 hours - 5 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan. 28, 1957, to Jan 28, 1957, that I last saw the deceased alive on Jan. 28, 1957, and that death occurred at 1:30 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews Jr.				ADDRESS (Street, city or town, state) 233 E. Main St.		DATE SIGNED 1/28/57	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS JR. M.D.				Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 29, 1957		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East Cal. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				ADDRESS North East		24a. REC'D BY REGISTRAR DATE 1/29/57	
				24b. REGISTRAR'S SIGNATURE J R Frazer			

2017192846

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
MARITAL STATUS		OCCUPATION		EDUCATION		RELIGION		MANNER OF DEATH		CAUSE OF DEATH		IMMEDIATE CAUSE OF DEATH		UNDERLYING CAUSE OF DEATH	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL		SIGNATURE OF CREMATION	

BUREAU V. S.

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502 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 3½ hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Rebecca Jane Lookard				4. DATE OF DEATH Month Day Year January 7 19 57			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1955	
9. AGE (In years last birthday) 1		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Howard E. Lockard, Sr.				14. MOTHER'S MAIDEN NAME Helen Tester			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Howard E. Lockard North East, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 340.0 DUE TO Meningitis due to type B/H. Influenza. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan. 5, 19 57, to Jan. 7, 19 57, that I last saw the deceased alive on Jan. 7, 19 57, and that death occurred at 6 P.M. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D.							
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr.				233 E. Main St., Elkton, Md. 1/9/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-1957		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Grant				ADDRESS North East, Md.		24a. REC'D BY REGISTRAR DATE 1/10/57	
				24b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

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BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00523

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural		c. LENGTH OF STAY IN 1b All life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Miller Last Lum				4. DATE OF DEATH Month 1-12 Day 19 Year 58			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-6-1888		9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Wright		10b. KIND OF BUSINESS OR INDUSTRY Building ships		11. BIRTHPLACE (State or foreign country) Cecil County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Lum				14. MOTHER'S MAIDEN NAME Hannah Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 221-01-8421		17. INFORMANT Address Ellen Lum, North East, Rural, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-15-1957		22c. NAME OF CEMETERY OR CREMATORY St Augustine		22d. LOCATION (City, town, or county) (State) Chesapeake City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R Grant				ADDRESS North East, Md		24a. REC'D BY REGISTRAR DATE 1-15-57	
				24b. REGISTRAR'S SIGNATURE Sarah E. Rothermel			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		ZIP CODE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		POLITICAL PARTY	
CAUSE OF DEATH		MANNER OF DEATH		TIME OF DEATH		PLACE OF DEATH		DATE OF DEATH	
SIGNATURE OF EXAMINER		TITLE		DATE		TIME		PLACE	
SIGNATURE OF WITNESS		TITLE		DATE		TIME		PLACE	
SIGNATURE OF CORONER		TITLE		DATE		TIME		PLACE	
SIGNATURE OF JURY		TITLE		DATE		TIME		PLACE	
SIGNATURE OF JUDGE		TITLE		DATE		TIME		PLACE	
SIGNATURE OF CLERK		TITLE		DATE		TIME		PLACE	
SIGNATURE OF RECORDER		TITLE		DATE		TIME		PLACE	
SIGNATURE OF ARCHIVER		TITLE		DATE		TIME		PLACE	
SIGNATURE OF DISTRIBUTOR		TITLE		DATE		TIME		PLACE	
SIGNATURE OF DELIVERER		TITLE		DATE		TIME		PLACE	
SIGNATURE OF RECEIVER		TITLE		DATE		TIME		PLACE	
SIGNATURE OF WITNESS		TITLE		DATE		TIME		PLACE	
SIGNATURE OF CORONER		TITLE		DATE		TIME		PLACE	
SIGNATURE OF JURY		TITLE		DATE		TIME		PLACE	
SIGNATURE OF JUDGE		TITLE		DATE		TIME		PLACE	
SIGNATURE OF CLERK		TITLE		DATE		TIME		PLACE	
SIGNATURE OF RECORDER		TITLE		DATE		TIME		PLACE	
SIGNATURE OF ARCHIVER		TITLE		DATE		TIME		PLACE	
SIGNATURE OF DISTRIBUTOR		TITLE		DATE		TIME		PLACE	
SIGNATURE OF DELIVERER		TITLE		DATE		TIME		PLACE	
SIGNATURE OF RECEIVER		TITLE		DATE		TIME		PLACE	

BUREAU V. S.

JAN 18 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

9v

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HACKS POINT EARLEVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>MABLE</u> Middle <u>A.</u> Last <u>MAY</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 20, 1894</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ABRAHAM ALLEN</u>				14. MOTHER'S MAIDEN NAME <u>SALLIE JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>216-20-8430</u>		17. INFORMANT Address <u>EDWARD MAY, HACKS POINT, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Sigmoid fistula</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Operation for Kidney stones left kidney</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>3 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral staghorn calculi both kidneys for years.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> 19 <u>56</u> , to <u>Jan 28</u> 19 <u>57</u> , that I last saw the deceased alive on <u>7:45 a.m. Jan 28, 1957</u> , and that death occurred at <u>7:45 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Wallace Obenshain</u> M.D. <u>Cecilton, MD.</u> <u>1-30-57</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/31/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>JOHNTOWN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL EARLEVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Hellows</u>				24. REC'D BY REGISTRAR <u>Feb 1 1957</u>		25. REGISTRAR'S SIGNATURE <u>L. R. Frager</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

535

CERTIFICATE OF DEATH

Reg. Dist. No.

00525

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>Maryland</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				d. STREET ADDRESS <u>11089 Ave. A.</u>			
3. NAME OF DECEASED (Type or print) <u>Charles Elmer McCommon</u> First Middle Last				4. DATE OF DEATH <u>1/4/57</u> Month Day Year <u>19</u>			
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/23/1867</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>E.O. Tel. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Hayward Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John McCommons</u>				14. MOTHER'S MAIDEN NAME <u>Phyllis Clayton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Geo. G. Lynch, Perry Point Md.</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177x</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Carcinoma Prostate</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>5-3</u> , 19 <u>56</u> to <u>1-3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-3</u> , 19 <u>57</u> , and that death occurred at <u>3 A</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Dr. L. Lewis</u> M.D.				PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Hayward Co. Mo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brayton Lee Harvick</u> ADDRESS <u>Grace Md.</u>				24a. REC'D BY REGISTRAR <u>1/5/57</u>		24b. REGISTRAR'S SIGNATURE <u>Irene E. Baugherty</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00526 90

536

1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CECILTON		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY CECIL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 CECILTON		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First STANLEY Middle S. Last McCUBBIN		4. DATE OF DEATH Month JAN. Day 14 Year 1957		5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH AUG. 13, 1882		9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCER STORE		10b. KIND OF BUSINESS OR INDUSTRY STORE		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME FLETCHER McCUBBIN		14. MOTHER'S MAIDEN NAME MARY HUNT		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-34-2132	
17. INFORMANT MRS. EMMA McCUBBIN		Address CECILTON, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 12 hours years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bed fast for 1 year - tube fed - 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Jan _____, 19 56 , to Jan _____, 19 57 , that I last saw the deceased alive on Jan 14 _____, 19 57 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/17/57		22c. NAME OF CEMETERY OR CREMATORY CECILTON CEM.	
22d. LOCATION (City, town, or county) (State) CECILTON MD.		23. FUNERAL DIRECTOR'S SIGNATURE Edward Holloway		23a. ADDRESS Mullington Rd.		23b. REC'D BY REGISTRAR Mrs. Ralph Rees		23c. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PREVIOUS ILLNESS		14. PREVIOUS SURGERY		15. PREVIOUS TRAUMA		16. PREVIOUS DRUGS	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESS		20. SIGNATURE OF DECEASED		21. SIGNATURE OF NEXT OF KIN		22. SIGNATURE OF BURIAL OFFICIAL		23. SIGNATURE OF FUNERAL HOME		24. SIGNATURE OF CEMETERY	

BUREAU V. 3

JAN 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00527

504

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Rising Sun			
				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Emma Wilson McNamee				4. DATE OF DEATH Month Day Year Jan. 28 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1876	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Rising Sun, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Charles Wilson				14. MOTHER'S MAIDEN NAME Elizabeth Fisher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT William McNamee		Address Rising Sun, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-26-57, 19, to 1-28, 1957, that I last saw the deceased alive on 1-28-1957, and that death occurred at 1-30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 1-29-57 ACTUAL SIGNATURE R.C. Dodson M.D. PHYSICIAN'S NAME (Type) R.C. Dodson Rising Sun, Cecil Co. Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Brookview		22d. LOCATION (City, town, or county) (State) Rising Sun Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A.E. Tyson				ADDRESS Rising Sun, Md.		24a. REC'D BY REGISTRAR DATE 1/31/57	
				24b. REGISTRAR'S SIGNATURE J.P. Frazer			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
13. NAME OF DECEASED		14. SEX		15. AGE		16. RACE		17. DATE OF BIRTH		18. PLACE OF BIRTH		19. DATE OF DEATH		20. PLACE OF DEATH		21. CAUSE OF DEATH		22. MANNER OF DEATH		23. SIGNATURE OF REGISTRAR		24. SIGNATURE OF DECEASED	
25. NAME OF DECEASED		26. SEX		27. AGE		28. RACE		29. DATE OF BIRTH		30. PLACE OF BIRTH		31. DATE OF DEATH		32. PLACE OF DEATH		33. CAUSE OF DEATH		34. MANNER OF DEATH		35. SIGNATURE OF REGISTRAR		36. SIGNATURE OF DECEASED	
37. NAME OF DECEASED		38. SEX		39. AGE		40. RACE		41. DATE OF BIRTH		42. PLACE OF BIRTH		43. DATE OF DEATH		44. PLACE OF DEATH		45. CAUSE OF DEATH		46. MANNER OF DEATH		47. SIGNATURE OF REGISTRAR		48. SIGNATURE OF DECEASED	
49. NAME OF DECEASED		50. SEX		51. AGE		52. RACE		53. DATE OF BIRTH		54. PLACE OF BIRTH		55. DATE OF DEATH		56. PLACE OF DEATH		57. CAUSE OF DEATH		58. MANNER OF DEATH		59. SIGNATURE OF REGISTRAR		60. SIGNATURE OF DECEASED	
61. NAME OF DECEASED		62. SEX		63. AGE		64. RACE		65. DATE OF BIRTH		66. PLACE OF BIRTH		67. DATE OF DEATH		68. PLACE OF DEATH		69. CAUSE OF DEATH		70. MANNER OF DEATH		71. SIGNATURE OF REGISTRAR		72. SIGNATURE OF DECEASED	
73. NAME OF DECEASED		74. SEX		75. AGE		76. RACE		77. DATE OF BIRTH		78. PLACE OF BIRTH		79. DATE OF DEATH		80. PLACE OF DEATH		81. CAUSE OF DEATH		82. MANNER OF DEATH		83. SIGNATURE OF REGISTRAR		84. SIGNATURE OF DECEASED	
85. NAME OF DECEASED		86. SEX		87. AGE		88. RACE		89. DATE OF BIRTH		90. PLACE OF BIRTH		91. DATE OF DEATH		92. PLACE OF DEATH		93. CAUSE OF DEATH		94. MANNER OF DEATH		95. SIGNATURE OF REGISTRAR		96. SIGNATURE OF DECEASED	
97. NAME OF DECEASED		98. SEX		99. AGE		100. RACE		101. DATE OF BIRTH		102. PLACE OF BIRTH		103. DATE OF DEATH		104. PLACE OF DEATH		105. CAUSE OF DEATH		106. MANNER OF DEATH		107. SIGNATURE OF REGISTRAR		108. SIGNATURE OF DECEASED	
109. NAME OF DECEASED		110. SEX		111. AGE		112. RACE		113. DATE OF BIRTH		114. PLACE OF BIRTH		115. DATE OF DEATH		116. PLACE OF DEATH		117. CAUSE OF DEATH		118. MANNER OF DEATH		119. SIGNATURE OF REGISTRAR		120. SIGNATURE OF DECEASED	
121. NAME OF DECEASED		122. SEX		123. AGE		124. RACE		125. DATE OF BIRTH		126. PLACE OF BIRTH		127. DATE OF DEATH		128. PLACE OF DEATH		129. CAUSE OF DEATH		130. MANNER OF DEATH		131. SIGNATURE OF REGISTRAR		132. SIGNATURE OF DECEASED	
133. NAME OF DECEASED		134. SEX		135. AGE		136. RACE		137. DATE OF BIRTH		138. PLACE OF BIRTH		139. DATE OF DEATH		140. PLACE OF DEATH		141. CAUSE OF DEATH		142. MANNER OF DEATH		143. SIGNATURE OF REGISTRAR		144. SIGNATURE OF DECEASED	
145. NAME OF DECEASED		146. SEX		147. AGE		148. RACE		149. DATE OF BIRTH		150. PLACE OF BIRTH		151. DATE OF DEATH		152. PLACE OF DEATH		153. CAUSE OF DEATH		154. MANNER OF DEATH		155. SIGNATURE OF REGISTRAR		156. SIGNATURE OF DECEASED	
157. NAME OF DECEASED		158. SEX		159. AGE		160. RACE		161. DATE OF BIRTH		162. PLACE OF BIRTH		163. DATE OF DEATH		164. PLACE OF DEATH		165. CAUSE OF DEATH		166. MANNER OF DEATH		167. SIGNATURE OF REGISTRAR		168. SIGNATURE OF DECEASED	
169. NAME OF DECEASED		170. SEX		171. AGE		172. RACE		173. DATE OF BIRTH		174. PLACE OF BIRTH		175. DATE OF DEATH		176. PLACE OF DEATH		177. CAUSE OF DEATH		178. MANNER OF DEATH		179. SIGNATURE OF REGISTRAR		180. SIGNATURE OF DECEASED	
181. NAME OF DECEASED		182. SEX		183. AGE		184. RACE		185. DATE OF BIRTH		186. PLACE OF BIRTH		187. DATE OF DEATH		188. PLACE OF DEATH		189. CAUSE OF DEATH		190. MANNER OF DEATH		191. SIGNATURE OF REGISTRAR		192. SIGNATURE OF DECEASED	
193. NAME OF DECEASED		194. SEX		195. AGE		196. RACE		197. DATE OF BIRTH		198. PLACE OF BIRTH		199. DATE OF DEATH		200. PLACE OF DEATH		201. CAUSE OF DEATH		202. MANNER OF DEATH		203. SIGNATURE OF REGISTRAR		204. SIGNATURE OF DECEASED	
205. NAME OF DECEASED		206. SEX		207. AGE		208. RACE		209. DATE OF BIRTH		210. PLACE OF BIRTH		211. DATE OF DEATH		212. PLACE OF DEATH		213. CAUSE OF DEATH		214. MANNER OF DEATH		215. SIGNATURE OF REGISTRAR		216. SIGNATURE OF DECEASED	
217. NAME OF DECEASED		218. SEX		219. AGE		220. RACE		221. DATE OF BIRTH		222. PLACE OF BIRTH		223. DATE OF DEATH		224. PLACE OF DEATH		225. CAUSE OF DEATH		226. MANNER OF DEATH		227. SIGNATURE OF REGISTRAR		228. SIGNATURE OF DECEASED	
229. NAME OF DECEASED		230. SEX		231. AGE		232. RACE		233. DATE OF BIRTH		234. PLACE OF BIRTH		235. DATE OF DEATH		236. PLACE OF DEATH		237. CAUSE OF DEATH		238. MANNER OF DEATH		239. SIGNATURE OF REGISTRAR		240. SIGNATURE OF DECEASED	
241. NAME OF DECEASED		242. SEX		243. AGE		244. RACE		245. DATE OF BIRTH		246. PLACE OF BIRTH		247. DATE OF DEATH		248. PLACE OF DEATH		249. CAUSE OF DEATH		250. MANNER OF DEATH		251. SIGNATURE OF REGISTRAR		252. SIGNATURE OF DECEASED	
253. NAME OF DECEASED		254. SEX		255. AGE		256. RACE		257. DATE OF BIRTH		258. PLACE OF BIRTH		259. DATE OF DEATH		260. PLACE OF DEATH		261. CAUSE OF DEATH		262. MANNER OF DEATH		263. SIGNATURE OF REGISTRAR		264. SIGNATURE OF DECEASED	
265. NAME OF DECEASED		266. SEX		267. AGE		268. RACE		269. DATE OF BIRTH		270. PLACE OF BIRTH		271. DATE OF DEATH		272. PLACE OF DEATH		273. CAUSE OF DEATH		274. MANNER OF DEATH		275. SIGNATURE OF REGISTRAR		276. SIGNATURE OF DECEASED	
277. NAME OF DECEASED		278. SEX		279. AGE		280. RACE		281. DATE OF BIRTH		282. PLACE OF BIRTH		283. DATE OF DEATH		284. PLACE OF DEATH		285. CAUSE OF DEATH		286. MANNER OF DEATH		287. SIGNATURE OF REGISTRAR		288. SIGNATURE OF DECEASED	
289. NAME OF DECEASED		290. SEX		291. AGE		292. RACE		293. DATE OF BIRTH		294. PLACE OF BIRTH		295. DATE OF DEATH		296. PLACE OF DEATH		297. CAUSE OF DEATH		298. MANNER OF DEATH		299. SIGNATURE OF REGISTRAR		300. SIGNATURE OF DECEASED	
301. NAME OF DECEASED		302. SEX		303. AGE		304. RACE		305. DATE OF BIRTH		306. PLACE OF BIRTH		307. DATE OF DEATH		308. PLACE OF DEATH		309. CAUSE OF DEATH		310. MANNER OF DEATH		311. SIGNATURE OF REGISTRAR		312. SIGNATURE OF DECEASED	
313. NAME OF DECEASED		314. SEX		315. AGE		316. RACE		317. DATE OF BIRTH		318. PLACE OF BIRTH		319. DATE OF DEATH		320. PLACE OF DEATH		321. CAUSE OF DEATH		322. MANNER OF DEATH		323. SIGNATURE OF REGISTRAR		324. SIGNATURE OF DECEASED	
325. NAME OF DECEASED		326. SEX		327. AGE		328. RACE		329. DATE OF BIRTH		330. PLACE OF BIRTH		331. DATE OF DEATH		332. PLACE OF DEATH		333. CAUSE OF DEATH		334. MANNER OF DEATH		335. SIGNATURE OF REGISTRAR		336. SIGNATURE OF DECEASED	
337. NAME OF DECEASED		338. SEX		339. AGE		340. RACE		341. DATE OF BIRTH		342. PLACE OF BIRTH		343. DATE OF DEATH		344. PLACE OF DEATH		345. CAUSE OF DEATH		346. MANNER OF DEATH		347. SIGNATURE OF REGISTRAR		348. SIGNATURE OF DECEASED	
349. NAME OF DECEASED		350. SEX		351. AGE		352. RACE		353. DATE OF BIRTH		354. PLACE OF BIRTH		355. DATE OF DEATH		356. PLACE OF DEATH		357. CAUSE OF DEATH		358. MANNER OF DEATH		359. SIGNATURE OF REGISTRAR		360. SIGNATURE OF DECEASED	
361. NAME OF DECEASED		362. SEX		363. AGE		364. RACE		365. DATE OF BIRTH		366. PLACE OF BIRTH		367. DATE OF DEATH		368. PLACE OF DEATH		369. CAUSE OF DEATH		370. MANNER OF DEATH		371. SIGNATURE OF REGISTRAR		372. SIGNATURE OF DECEASED	
373. NAME OF DECEASED		374. SEX		375. AGE		376. RACE		377. DATE OF BIRTH		378. PLACE OF BIRTH		379. DATE OF DEATH		380. PLACE OF DEATH		381. CAUSE OF DEATH		382. MANNER OF DEATH		383. SIGNATURE OF REGISTRAR		384. SIGNATURE OF DECEASED	
385. NAME OF DECEASED		386. SEX		387. AGE		388. RACE		389. DATE OF BIRTH		390. PLACE OF BIRTH		391. DATE OF DEATH		392. PLACE OF DEATH		393. CAUSE OF DEATH		394. MANNER OF DEATH		395. SIGNATURE OF REGISTRAR		396. SIGNATURE OF DECEASED	
397. NAME OF DECEASED		398. SEX		399. AGE		400. RACE		401. DATE OF BIRTH		402. PLACE OF BIRTH		403. DATE OF DEATH		404. PLACE OF DEATH		405. CAUSE OF DEATH		406. MANNER OF DEATH		407. SIGNATURE OF REGISTRAR		408. SIGNATURE OF DECEASED	
409. NAME OF DECEASED		410. SEX		411. AGE		412. RACE		413. DATE OF BIRTH		414. PLACE OF BIRTH		415. DATE OF DEATH		416. PLACE OF DEATH		417. CAUSE OF DEATH		418. MANNER OF DEATH		419. SIGNATURE OF REGISTRAR		420. SIGNATURE OF DECEASED	
421. NAME OF DECEASED		422. SEX		423. AGE		424. RACE		425. DATE OF BIRTH		426. PLACE OF BIRTH		427. DATE OF DEATH		428. PLACE OF DEATH		429. CAUSE OF DEATH		430. MANNER OF DEATH		431. SIGNATURE OF REGISTRAR		432. SIGNATURE OF DECEASED	
433. NAME OF DECEASED		434. SEX		435. AGE		436. RACE		437. DATE OF BIRTH		438. PLACE OF BIRTH		439. DATE OF DEATH		440. PLACE OF DEATH		441. CAUSE OF DEATH		442. MANNER OF DEATH		443. SIGNATURE OF REGISTRAR		444. SIGNATURE OF DECEASED	
445. NAME OF DECEASED		446. SEX		447. AGE		448. RACE		449. DATE OF BIRTH		450. PLACE OF BIRTH		451. DATE OF DEATH		452. PLACE OF DEATH		453. CAUSE OF DEATH		454. MANNER OF DEATH		455. SIGNATURE OF REGISTRAR		456. SIGNATURE OF DECEASED	
457. NAME OF DECEASED		458. SEX		459. AGE		460. RACE		461. DATE OF BIRTH		462. PLACE OF BIRTH		463. DATE OF DEATH		464. PLACE OF DEATH		465. CAUSE OF DEATH		466. MANNER OF DEATH		467. SIGNATURE OF REGISTRAR		468. SIGNATURE OF DECEASED	
469. NAME OF DECEASED		470. SEX		471. AGE		472. RACE		473. DATE OF BIRTH		474. PLACE OF BIRTH		475. DATE OF DEATH		476. PLACE OF DEATH		477. CAUSE OF DEATH		478. MANNER OF DEATH		479. SIGNATURE OF REGISTRAR		480. SIGNATURE OF DECEASED	
481. NAME OF DECEASED		482. SEX		483. AGE		484. RACE		485. DATE OF BIRTH		486. PLACE OF BIRTH		487. DATE OF DEATH		488. PLACE OF DEATH		489. CAUSE OF DEATH		490. MANNER OF DEATH		491. SIGNATURE OF REGISTRAR		492. SIGNATURE OF DECEASED	
493. NAME OF DECEASED		494. SEX		495. AGE		496. RACE		497. DATE OF BIRTH		498. PLACE OF BIRTH		499. DATE OF DEATH		500. PLACE OF DEATH		501. CAUSE OF DEATH		502. MANNER OF DEATH		503. SIGNATURE OF REGISTRAR		504. SIGNATURE OF DECEASED	
505. NAME OF DECEASED		506. SEX		507. AGE		508. RACE		509. DATE OF BIRTH		510. PLACE OF BIRTH		511. DATE OF DEATH		512. PLACE OF DEATH		513. CAUSE OF DEATH		514. MANNER OF DEATH		515. SIGNATURE OF REGISTRAR		516. SIGNATURE OF DECEASED	
517. NAME OF DECEASED		518. SEX		519. AGE		520. RACE		521. DATE OF BIRTH		522. PLACE OF BIRTH		523. DATE OF DEATH		524. PLACE OF DEATH		525. CAUSE OF DEATH		526. MANNER OF DEATH		527. SIGNATURE OF REGISTRAR		528. SIGNATURE OF DECEASED	
529. NAME OF DECEASED		530. SEX		531. AGE		532. RACE		533. DATE OF BIRTH		534. PLACE OF BIRTH		535. DATE OF DEATH		536. PLACE OF DEATH		537. CAUSE OF DEATH		538. MANNER OF DEATH		539. SIGNATURE OF REGISTRAR		540. SIGNATURE OF DECEASED	
541. NAME OF DECEASED		542. SEX		543. AGE		544. RACE		545. DATE OF BIRTH		546. PLACE OF BIRTH		547. DATE OF DEATH		548. PLACE OF DEATH		549. CAUSE OF DEATH		550. MANNER OF DEATH		551. SIGNATURE OF REGISTRAR		552. SIGNATURE OF DECEASED	
553. NAME OF DECEASED		554. SEX		555. AGE		556. RACE		557. DATE OF BIRTH		558. PLACE OF BIRTH		559. DATE OF DEATH		560. PLACE OF DEATH		561. CAUSE OF DEATH		562. MANNER OF DEATH		563. SIGNATURE OF REGISTRAR		564. SIGNATURE OF DECEASED	
565. NAME OF DECEASED		566. SEX		567. AGE		568. RACE		569. DATE OF BIRTH		570. PLACE OF BIRTH		571. DATE OF DEATH		572. PLACE OF DEATH		573. CAUSE OF DEATH		574. MANNER OF DEATH		575. SIGNATURE OF REGISTRAR		576. SIGNATURE OF DECEASED	
577. NAME OF DECEASED		578. SEX		579. AGE		580. RACE		581. DATE OF BIRTH		582. PLACE OF BIRTH		583. DATE OF DEATH		584. PLACE OF DEATH		585. CAUSE OF DEATH		586. MANNER OF DEATH		587. SIGNATURE OF REGISTRAR		588. SIGNATURE OF DECEASED	
589. NAME OF DECEASED		590. SEX		591. AGE		592. RACE		593. DATE OF BIRTH		594. PLACE OF BIRTH		595. DATE OF DEATH		596. PLACE OF DEATH		597. CAUSE OF DEATH		598. MANNER OF DEATH		599. SIGNATURE OF REGISTRAR		600. SIGNATURE OF DECEASED	
601. NAME OF DECEASED		602. SEX		603. AGE		604. RACE		605. DATE OF BIRTH		606. PLACE OF BIRTH		607. DATE OF DEATH		608. PLACE OF DEATH		609. CAUSE OF DEATH		610. MANNER OF DEATH		611. SIGNATURE OF REGISTRAR		612. SIGNATURE OF DECEASED	
613. NAME OF DECEASED		614. SEX		615. AGE		616. RACE		617. DATE OF BIRTH		618. PLACE OF BIRTH		619. DATE OF DEATH		620. PLACE OF DEATH		621. CAUSE OF DEATH		622. MANNER OF DEATH		623. SIGNATURE OF REGISTRAR		624. SIGNATURE OF DECEASED	
625. NAME OF DECEASED		626. SEX		627. AGE		628. RACE		629. DATE OF BIRTH		630. PLACE OF BIRTH		631. DATE OF DEATH		632. PLACE OF DEATH		633. CAUSE OF DEATH		634. MANNER OF DEATH		635. SIGNATURE OF REGISTRAR		636. SIGNATURE OF DECEASED	
637. NAME OF DECEASED		638. SEX		639. AGE		640. RACE		641. DATE OF BIRTH		642. PLACE OF BIRTH		643. DATE OF DEATH		644. PLACE OF DEATH		645. CAUSE OF DEATH		646. MANNER OF DEATH		647. SIGNATURE OF REGISTRAR		648. SIGNATURE OF DECEASED	
649. NAME OF DECEASED		650. SEX		651. AGE		652. RACE		653. DATE OF BIRTH		654. PLACE OF BIRTH		655. DATE OF DEATH		656. PLACE OF DEATH		657. CAUSE OF DEATH		658. MANNER OF DEATH		659. SIGNATURE OF REGISTRAR		660. SIGNATURE OF DECEASED	
661. NAME OF DECEASED		662. SEX		663. AGE		664. RACE		665. DATE OF BIRTH		666. PLACE OF BIRTH		667. DATE OF DEATH		668. PLACE OF DEATH		669. CAUSE OF DEATH		670. MANNER OF DEATH		671. SIGNATURE OF REGISTRAR		672. SIGNATURE OF DECEASED	
673. NAME OF DECEASED		674. SEX		675. AGE		676. RACE		677. DATE OF BIRTH		678. PLACE OF BIRTH		679. DATE OF DEATH		680. PLACE OF DEATH		681. CAUSE OF DEATH		682. MANNER OF DEATH		683. SIGNATURE OF REGISTRAR		684. SIGNATURE OF DECEASED	
685. NAME OF DECEASED		686. SEX		687. AGE		688. RACE		689. DATE OF BIRTH		690. PLACE OF BIRTH		691. DATE OF DEATH		692. PLACE OF DEATH		693. CAUSE OF DEATH		694. MANNER OF DEATH		695. SIGNATURE OF REGISTRAR		696. SIGNATURE OF DECEASED	
697. NAME OF DECEASED		698. SEX		699. AGE		700. RACE		701. DATE OF BIRTH		702. PLACE OF BIRTH		703. DATE OF DEATH		704. PLACE OF DEATH									

537 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY Washington,	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X3 Washington,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 3317 Holmead Pl., N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle MELTON Last MELTON		4. DATE OF DEATH Month January Day 5 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 26, 1934
9. AGE (In years lost birthday) yrs. 22		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Marshall Melton Ruffing		14. MOTHER'S MAIDEN NAME Hannah Melton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 579-48-0568	
17. INFORMANT Hospital Records, VAH., Perry Point, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation due to unknown cause, 221X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Edema, pulmonary, bilateral, severe DUE TO Excision of (c) Surgery - Pilonidal cyst (Post-operative) Date of operation 24 hours 1-3-57 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 2, 1957 , to January 5, 1957 , that death occurred at 12:55 A.M. , from the causes and on the date stated above. and that death occurred at 12:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 1-7-57 ACTUAL SIGNATURE W. Oppler M.D. Director, Professional Services. PHYSICIAN'S NAME (Type) W. OPPLER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-7-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son,		ADDRESS Havre DeGrace, Md.	
24a. REC'D BY REGISTRAR DATE Jan 9-57		24b. REGISTRAR'S SIGNATURE Ernest E. Dougherty	

BUREAU V. S.

JAN 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00529

538

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 11 mo. 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS 3308 N. Calvert		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CHARLES Middle D. Last MILLER			4. DATE OF DEATH Month January Day 21 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-2-90		9. AGE (In years lost birthday) yrs. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Nebraska	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME William H. Miller - Deceased		
14. MOTHER'S MAIDEN NAME Myrtle M. Roberts - Deceased			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		
16. SOCIAL SECURITY NO. WW I		17. INFORMANT Hospital Records, VAH, Perry Point, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma of right lung with re- currence into right pleural cavity and hilar lymph nodes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 162x (c) 162x	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis general severe - unknown. Absence of the right lung acquired 3-21-56.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA		20g. (County) VA		20h. (State) VA	
21. I certify that I attended the deceased from February 3, 1956 to January 21, 1957 , and that death occurred at 5:20 a.m. from the causes and on the date stated above.					
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.			
DATE SIGNED 1-21-57		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-21-57		22c. NAME OF CEMETERY OR CREMATORY unknown	
22d. LOCATION (City, town, or county) Gerardstown, West Virginia		(State) West Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Sons		ADDRESS Hayre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 1-21-57	
24b. REGISTRAR'S SIGNATURE Inene E. Dougherty					

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00530

539

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Rowlandville</u>	
c. LENGTH OF STAY IN 1b <u>2 Hrs.</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dean</u> Middle <u>Moore</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>15</u> Year <u>57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>15</u> Hours <u>19</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>	11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John W. Moore</u>	
14. MOTHER'S MAIDEN NAME <u>Ellen Parsons</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>316-05-8164</u>		17. INFORMANT <u>Mrs. Dean Moore</u> Address <u>Rowlandville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Unmed</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>55</u> , to <u>Jan 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 14</u> , 19 <u>57</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gudley Phillips</u> M.D.		ADDRESS (Street, city or town, state) <u>Darlington Md</u> DATE SIGNED <u>1/17/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 19, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>	22d. LOCATION (City, town, or county) (State) <u>Near Coloma Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson, Rising Sun, Md.</u>		24. REC'D BY REGISTRAR <u>Jan 17-56</u>	25. REGISTRAR'S SIGNATURE <u>L. M. M. M. M. M.</u>

BUREAU V. 8

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00531

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN lb <u>4 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Cowantown, Elkton. Md. R.D.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Dale</u> Middle <u>A</u> Last <u>Poarch</u>				4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 27 1950</u>		9. AGE (In years last birthday) <u>6</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>31</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School Boy</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arvis S. Poarch</u>				14. MOTHER'S MAIDEN NAME <u>Helen Skompski</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Arvis S. Poarch, Elkton, R.D. 4 Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforating wound of chest left side at</u> <u>919.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>10 interspacegoing through diaphragm left</u> (c) <u>kidney, colon and head of pancreas and</u> <u>came out 3 inches above pelvis</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was shot by 22 caliber Rifle</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>3.30</u> a.m. <u>1-31-57</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Elkton Cecil Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u>		EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2-1-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-3-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Mem. Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Elktpn Cecil Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Tippen</u>				24a. REC'D BY REGISTRAR <u>2/6/57</u>		24b. REGISTRAR'S SIGNATURE <u>FR Trauer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

RECEIVED

DEC 7 1957

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00532

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colora		c. LENGTH OF STAY IN 1b 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colora		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Vernon Middle Wilson Last Preston				4. DATE OF DEATH Month 1 Day 6 Year 1957			
5. SEX M.		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-11-1903	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Preston				14. MOTHER'S MAIDEN NAME Ella Gamble			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W.2 145-05-2617		17. INFORMANT Mrs. Arthur Nevitt, Haddonfield, N.J.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute Alcoholism (c) stopping the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 1-8-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-57		22c. NAME OF CEMETERY OR CREMATORY Oxford Cem.		22d. LOCATION (City, town, or county) (State) Oxford, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson				24a. REC'D BY REGISTER Jan 11 1957		24b. REGISTRAR'S SIGNATURE L. M. Nottingham	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
RACE [Faint text]		OCCUPATION [Faint text]		PLACE OF BIRTH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		SIGNATURE OF EXAMINER [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF WITNESS [Faint text]	

BUREAU V. B.

JAN 10 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

541

CERTIFICATE OF DEATH

00533

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 16th & Q. Streets, N.W.	
3. NAME OF DECEASED (Type or print) First HAZAR Middle F. Last PULATIN		4. DATE OF DEATH Month January Day 11 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-94
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Bronchopneumonia, bilateral, lower lobes, unresolved DUE TO (b) Coronary heart disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general, severe - unknown			INTERVAL BETWEEN ONSET AND DEATH 7-10 days unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 21, 19 33, to January 11, 19 57, and that death occurred at 11:15 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		M.D. V.A. Hospital, Perry Point, Md. DATE SIGNED 1-14-57	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-14-57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE Jan 17-57	
		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

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506 CERTIFICATE OF DEATH

00534

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Elkton		LENGTH OF STAY (in this place) one week		CITY (If outside corporate limits, write RURAL end give nearest town) TOWN Elkton			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Devine Nursing Home				STREET ADDRESS 428 North Street (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) M (Middle) Virginia (Last) Reed.				Jan 10 1957			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 86yrs	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Reed				14. MOTHER'S MAIDEN NAME Margaret Ferguson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Miss Ada Reed, 428 North St., Elkton, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
782.4 IMMEDIATE CAUSE (A) Cardiac Failure						INTERVAL BETWEEN ONSET AND DEATH Jan. 9, 1957	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 29, 1956, to Jan 10, 1957, that I last saw the deceased alive on Jan 10, 1957, and that death occurred at 11:20 P.M. from the causes and on the date stated above.							
SIGNATURE Dr. J. P. Sprague, M.D.				ADDRESS (Street, city, town, state) Spartanburg, S.C.		DATE SIGNED Jan 10, 1957	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1-13-57		NAME OF CEMETERY OR CREMATORY Bayview Methodist Cemetery		LOCATION (City, town, or county) (State) Bayview, Cecil Co. Md.	
24. REC'D BY REGISTRAR DATE Jan 11, 1957		REGISTRAR'S SIGNATURE J. P. Sprague		25. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Sprague		ADDRESS North East, Md.	

INSTRUCTIONS

1. **ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. A copy of this certificate must be retained by the hospital or attending physician.

2. **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

Reg. Dist. No.

1. DEATH OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

542

CERTIFICATE OF DEATH

00535
Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b Lyr. 3mo. 18days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 83X-3	
3. NAME OF DECEASED (Type or print) First ROBERT Middle K. Last REEVES		4. DATE OF DEATH Month January Day 7 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-25-07
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dispatcher		10b. KIND OF BUSINESS OR INDUSTRY Cab Company	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lundy Reeves		14. MOTHER'S MAIDEN NAME Mary Pickett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 229 14 5313	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial fibrosis interventricular septum 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic coronary heart disease, severe DUE TO (c) Arteriosclerosis, general		INTERVAL BETWEEN ONSET AND DEATH unknown unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 20, 19 55, to January 7, 19 57, and that death occurred at 11:20 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) W. OPPLER		V.A. Hospital, Perry Point, Md. 1-8-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-8-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 1-11-57	
		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

507

CERTIFICATE OF DEATH

00536

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14x12 Kennedyville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry -Scotten-- First Scotten Middle Scotten Last =Harry				4. DATE OF DEATH Month January Day 10 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/26/82		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer (retired)		10b. KIND OF BUSINESS OR INDUSTRY owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown John Scotten				14. MOTHER'S MAIDEN NAME Unknown Sarah E. Greenwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Robert Sutton		Address Kennedyville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Dehydration and cerebral arteriosclerosis DUE TO (c) years						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 151x Carcinoma of Stomach						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 19 57 , to Jan 10 , 19 57 , that I last saw the deceased alive on Jan 10 , 19 57 , and that death occurred at 14h M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cecilton, Md DATE SIGNED 10 Jan 57							
ACTUAL SIGNATURE Wallace Obenshain		M.D. Cecilton, Md		16 Jan 57			
PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/57		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE JAN 14 1957	
				24b. REGISTRAR'S SIGNATURE F. R. L. L. L.			

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 14 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>	
10. SIGNATURE OF DECEASED <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF DECEASED <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>		21. SIGNATURE OF DECEASED <i>John Doe</i>	
22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>	
28. SIGNATURE OF DECEASED <i>John Doe</i>		29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF DECEASED <i>John Doe</i>		33. SIGNATURE OF DECEASED <i>John Doe</i>	
34. SIGNATURE OF DECEASED <i>John Doe</i>		35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF DECEASED <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>John Doe</i>		39. SIGNATURE OF DECEASED <i>John Doe</i>	
40. SIGNATURE OF DECEASED <i>John Doe</i>		41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF DECEASED <i>John Doe</i>	
43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF DECEASED <i>John Doe</i>		45. SIGNATURE OF DECEASED <i>John Doe</i>	
46. SIGNATURE OF DECEASED <i>John Doe</i>		47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF DECEASED <i>John Doe</i>		51. SIGNATURE OF DECEASED <i>John Doe</i>	
52. SIGNATURE OF DECEASED <i>John Doe</i>		53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF DECEASED <i>John Doe</i>	
55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF DECEASED <i>John Doe</i>		57. SIGNATURE OF DECEASED <i>John Doe</i>	
58. SIGNATURE OF DECEASED <i>John Doe</i>		59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF DECEASED <i>John Doe</i>		63. SIGNATURE OF DECEASED <i>John Doe</i>	
64. SIGNATURE OF DECEASED <i>John Doe</i>		65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF DECEASED <i>John Doe</i>	
67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF DECEASED <i>John Doe</i>		69. SIGNATURE OF DECEASED <i>John Doe</i>	
70. SIGNATURE OF DECEASED <i>John Doe</i>		71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF DECEASED <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF DECEASED <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>	
76. SIGNATURE OF DECEASED <i>John Doe</i>		77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>John Doe</i>		81. SIGNATURE OF DECEASED <i>John Doe</i>	
82. SIGNATURE OF DECEASED <i>John Doe</i>		83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF DECEASED <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF DECEASED <i>John Doe</i>		87. SIGNATURE OF DECEASED <i>John Doe</i>	
88. SIGNATURE OF DECEASED <i>John Doe</i>		89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF DECEASED <i>John Doe</i>		93. SIGNATURE OF DECEASED <i>John Doe</i>	
94. SIGNATURE OF DECEASED <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>	
100. SIGNATURE OF DECEASED <i>John Doe</i>		101. SIGNATURE OF DECEASED <i>John Doe</i>		102. SIGNATURE OF DECEASED <i>John Doe</i>	

BUREAU V. S.

JAN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00537

508

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby</u> First Middle Last <u>Simmonds</u>				4. DATE OF DEATH <u>JANUARY 18 1957</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/18/57</u>		9. AGE (In years last birthday) yrs. <u>1</u> <u>10</u> Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Robert Alley</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Simmonds</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT <u>Mother</u> Address <u>Elkton R.D. 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature Birth</u> <u>5 1/2 months</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>(Unknown)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/18</u> , 19 <u>57</u> , to <u>1/18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/18</u> , 19 <u>57</u> , and that death occurred at <u>10:03</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James H. Johnson</u> M.D. <u>245 E. High St., Elkton, Md.</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>James L. Johnson MD</u> <u>245 E. High St., Elkton, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 19, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill MeTh Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Cecil County Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u> ADDRESS <u>103 STOCKTON ST. ELKTON, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>1/19/57</u>		24b. REGISTRAR'S SIGNATURE <u>FRF</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00538

543

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Charlestown</u>		LENGTH OF STAY (in this place) <u>5 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>North East</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Stanley</u> (First) <u>M</u> (Middle) <u>Smith</u> (Last)				4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>13</u> (Year) <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 21, 1878</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. Starrett Smith</u>				14. MOTHER'S MAIDEN NAME <u>Emma Louise Russell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-20-8675</u>		17. INFORMANT & ADDRESS <u>Mrs. Harold Shea, North East, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>HEART ARREST</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 MIN</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>GENERALIZED ARTERIOSCLEROSIS, ESP CORONARY</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>OLD AGE</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>KIDNEY DAMAGE, CHRONIC PYELONEPHRITIS</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>NOV 4, 1956</u>, to <u>JAN 13, 1957</u>, that I last saw the deceased alive on <u>JAN 13, 1957</u>, and that death occurred at <u>2:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>O. H. Vogel</u>		M. D.		ADDRESS (Street, city, town, state) <u>CECIL AVE. N.E.</u>		DATE SIGNED <u>1-15-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 16, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Rosebank Cemetery</u>		LOCATION (City, town, or county) (State) <u>Calvert Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>1-16-57</u>		REGISTRAR'S SIGNATURE <u>Sarah E. Rothermel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>		ADDRESS <u>North East, Md</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

DEATH CERTIFICATE NUMBER

MARYLAND

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

RELIGION

DATE OF BIRTH

DATE OF DEATH

DATE OF DEATH

BUREAU V. 3

JAN 18 1957

RECEIVED

NOTIFICATION

509

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN lb <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>M</u> Last <u>Stewart</u>				4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1 1876</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Isaiah Biddle</u>				14. MOTHER'S MAIDEN NAME <u>Kate Pierce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Harold T. Stewart</u> Address <u>Harold T. Stewart North East, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Rt. Cerebral Thrombosis with left Hemiplegia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Renal Disease</u> DUE TO (c) <u>10 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>20 Jan</u> , 1957, to <u>23 Jan</u> , 1957, that I last saw the deceased alive on <u>23 Jan</u> , 1957, and that death occurred at <u>10:24 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Klaus H. Huchner</u> M.D.				ADDRESS (Street, city or town, state) <u>North East Rd</u>		DATE SIGNED <u>25 Jan 57</u>	
PHYSICIAN'S NAME (Type) <u>Klaus H. Huchner M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 26, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>North East, Cecil, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph P. Lantz</u> ADDRESS <u>North East, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>1/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. P. Lantz</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore 18
 CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____		PLACE OF BIRTH _____	
OCCASION OF DEATH _____		PREVIOUS ILLNESS _____		PREVIOUS SURGERY _____	
NAME OF PHYSICIAN _____		NAME OF NURSE _____		NAME OF MINISTER _____	
NAME OF FUNERAL HOME _____		NAME OF BURIAL PLACE _____		NAME OF CEMETERY _____	
NAME OF INTERVIEWER _____		NAME OF WITNESS _____		NAME OF SIGNER _____	

BUREAU V. S.

JAN 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00540

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cherry St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>Duyckinck</u> Last <u>Ward</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>9</u> Year <u>19 57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>74</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cecil Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Aaron Longstreet Duyckinck</u>		14. MOTHER'S MAIDEN NAME <u>Williamina Ward Read</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Williamina Ward, Rising Sun, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO <u>Chronic Nephritis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Chronic Nephritis.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. C. Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-14-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Coloma, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. G. Carlson</u>		24a. REC'D BY REGISTRAR <u>Jan 10 - 57</u>	
ADDRESS <u>Rising Sun, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Emmington</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 14 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

545

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Sylmar		c. LENGTH OF STAY IN 1b 38 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle H Last Witman		4. DATE OF DEATH Month January Day 5 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Witman		14. MOTHER'S MAIDEN NAME Emma Steffy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Lidie Witman		Address Rising Sun, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured esophageal varices 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis of liver DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/1 , 19 56 to 1/5 , 19 57 , that I last saw the deceased alive on 1/4 , 19 57 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Neil R Taylor		ADDRESS (Street, city or town, state) Rising Sun, Md.	
PHYSICIAN'S NAME (Type) Neil R Taylor		DATE SIGNED 1/5/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/8/1957	
22c. NAME OF CEMETERY OR CREMATORY Brookview		22d. LOCATION (City, town, or county) (State) Rising Sun, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M Reed		ADDRESS Rising Sun, Md.	
24a. REC'D BY REGISTRAR Ralph M Reed		24b. REGISTRAR'S SIGNATURE Lowell Hargraves	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME

RESIDENCE

DATE

TIME

CAUSE OF DEATH

AGE

SEX

DATE

TIME

PLACE

DATE

TIME

PLACE

DATE

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BUREAU V. S.

JAN 8 1957

RECEIVED